HIV/PreP

Telephone: 1-888-216-6553; 443-707-6300
Fax: 1-888-216-6802; 410-728-5116
Website: https://totalhealthcarerx.org

patient information

patient: _____ ☐ male ☐ female DOB: _____ SS#: _____
(last name, first name)

address: _____
(street, city, state, zip)

primary phone number: _____ ☐ cell alternate phone number: _____ ☐ cell

caregiver: _____ allergies: _____ ☐ NKDA

comorbidities: _____ height: _____ weight: _____ ☐ lbs ☐ kg date: _____

clinical information

Diagnosis ICD-10: ☐ B20 HIV ☐ B18.0 HBV with delta agent (Chronic) ☐ B18.1 HBV without delta agent (Chronic) ☐ B18.2 HCV (Chronic)

New to current therapy? ☐ yes ☐ no CD4: _____ date: _____ HIV RNA: _____ date: _____

prescriptions

medication	QTY	refills
☐ Aptivus® (tipranavir) 250 mg Two capsules by mouth BID (Q12 hours)		
☐ Atripla® (EFV/FTC/TDF) 600/200/300 mg One tablet by mouth QD on an empty stomach		
☐ Combivir® (lamivudine/zidovudine) 150/300 mg One tablet by mouth BID (Q12 hours)		
☐ Complera™ (FTC/rilpivirine/TDF) 200/25/300 mg One tablet by mouth QD with food		
☐ Crixivan® (indinavir) One tablet by mouth QD with a meal		
☐ Edurant™ (rilpivirine) 25 mg One capsule by mouth QD		
☐ Emtrivia QD® (emtricitabine) 200 mg		
☐ Epivir® (lamivudine)		
☐ Epzicom® (abacavir/lamivudine) 600/300 mg One tablet by mouth QD		
☐ Fuzeon® (enfuviritide) 90 mg 90 mg (1 mL) Sub-Q BID (Q12 hours)		
☐ Fuzeon® (enfuviritide) 90 mg 90 mg (1 mL) Sub-Q BID (Q12 hours)		
☐ Intelence® (entravirine)		
☐ Invirase® (saquinavir)		
☐ Isentress® (raltegravir) 400 mg One tablet by mouth BID (Q12 hours)		
☐ Kaletra® (lopinavir/ritonavir) 200/50 mg		
☐ Lexiva® (fosamprenavir) 200/50 mg		
☐ Norvir® (ritonavir) capsules 100 mg		
☐ Norvir® (ritonavir) tablets 100 mg		
☐ Prezista® (darunavir)		
☐ Rescriptor® (delavirdine)		

medication	QTY	refills
☐ Retrovir® (zidovudine)		
☐ Reyataz® (atazanavir)		
☐ Selzentry® (maraviroc)		
☐ Stribid™ (EVG/COBI/FTC/TDF) 150/150/200/300 mg One tablet by mouth QD with food		
☐ Sustiva® (efavirenz)		
☐ Trizivir® (ABC/3TC/AZT) 300/150/300 mg One tablet by mouth BID (Q12 hours)		
☐ Truvada® (emtricitabine/tenofovir) 200/300 mg One tablet by mouth QD		
☐ Videx® EC (didanosine)		
☐ Viracept® (nelfinavir)		
☐ Viramune® (nevirapine) 200 mg		
☐ Viramune® XR™ (nevirapine ER) 400 mg One tablet by mouth QD		
☐ Viread® (tenofovir) 300 mg		
☐ Zerit® (stavudine)		
☐ Ziagen® (avacavir) 300 mg		
other medications		
☐		
☐		
☐		
☐		
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☐		
☐		
☐		

prescriber + shipping information

prescriber (print): _____ office contact: _____

preferred method of contact: ☐ phone ☐ fax ☐ emails preferred contact persons email: _____

ship to ☐ patient ☐ office ☐ alternate _____
(shipping address: street, city, state, zip)

office address: _____
(street, suite, city, state, zip)

phone: _____ fax: _____ NPI: _____ DEA: _____

prescriber's signature: _____ date: _____

I authorize Total Health Care Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above.
I understand that I can revoke this designation at any time by providing written notice to Total Health Care Specialty Pharmacy

insurance information: please fax copy of insurance card (front + back)